



THE SECLUSION AND RESTRAINT OF THE MENTALLY ILL CHILD

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THE SECLUSION AND RESTRAINT OF THE MENTALLY ILL CHILD

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Food and Drug Law

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The Food and Drug Administration's purpose is to serve the public and protect the public health. There's a general standard of safety and effectiveness for drugs and devices set by the Food and Drug Administration. In everyday life, individuals eat food, take medications and use medical devices and these activities are done for the most part voluntarily. Physicians, nutritionists, advertisers, and labelling may advise the public about what foods to eat, drugs to take, and devices to use, however the choice is still ultimately left to the consumer.

This situation differs from the situation a mentally ill child has to face in a mental institution. If a physician or staff member believes the child needs to be restrained or secluded, the child is restrained or secluded for the most part against her will. Therefore, the child is the involuntary consumer of these drugs and/or devices if they are used.

This paper will not delve into the exact FDA regulations on drugs used as chemical restraint, which would be major tranquilizers nor on medical devices used for mechanical restraints, such as ankle and wrist restraints. In fact, this paper will assume that the drugs and devices used for restraint and seclusion have passed the safety and effectiveness standards. Rather this paper will discuss a broad overview of the use of seclusion and restraint of children in mental institutions and its possible value and necessity to children and society. This paper will include the types of restraints used, the status of children in our society, justifications for seclusion and restraint, nonsupport of seclusion and restraint, a brief history of seclusion and restraint, the therapeutic value of seclusion, the variation in uses of seclusion

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and restraint, Youngberg v. Romeo the liability for the abuse of seclusion and restraint, and the guidelines as to when to seclude or restrain a child.

Types of Restraint and Seclusion

Seclusion and restraint of children are implemented in psychiatric in-patient units all over the country. The types of restraint and seclusion used to restrain a mentally ill child are mechanical restraint, chemical restraint, physical restraint and seclusion. Mechanical restraint is the use of a physical device to restrict patient movement or normal function of a portion of his/her body. Chemical restraint is the administration of medication, most likely a major tranquilizer in order to restrain or restrict the movement of a patient. Most of the time, this type of restraint is preceded by physical restraint, at least by physical holding.¹ Physical restraint is the use of bodily physical force to limit a patient's movement, such as physically holding a child, for more than a five minute interval. Seclusion is the placement of a patient in a room alone where a door or staff member might block the exit. Children's Right to Be Free v. State's Right to Intervene

All children need basic care and protection to make it through childhood. Children and adolescents struggle to survive in the world while simultaneously growing and absorbing life with immature resources. Moreover, childhood is associated with helplessness and vulnerability. These are some of the reasons why children are not given the rights nor responsibilities as adults in our society. Rather, extensive limits are placed on their personal freedom. In fact, all children are intrinsically committable

¹Donald S. Gair, Tuvenile Psychiatry and the Law (Richard Rosner & Harold Schwartz eds. 1989) p. 360.

²1d at 354.

³1d at 449.

⁴1dat 355.

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on the basis of inability to cope safely, even with no mental illness.
2 Children are dependent minors under obligatory supervision by

parents or other adults. When children are committed to a mental institution this status does not change. Rather their custody is shifted from one set of adults to another. During hospitalization children must be under the immediate supervision of responsible adults at all times. These adults have constant responsibility over these children and have the authority to make critical decisions during emergency situations as well as to engage in the treatment program for the child. The nursing staff are the caretakers of the children the great majority of the time.

Ethically, restraint or seclusion may seem to run counter with the proper treatment of children. However, there are times when children lack inner control and can present harm to themselves and physical danger to others. They may display destructiveness to property; chaotic, disruptive behavior; and inability to cope safely. Limitations are placed on children because of society's recognition of the necessity to protect children because of their inherent limitations in judgment and self-control. When children cannot control their own behavior, responsible adults must do it for them until they are able to do it for themselves.³

Restraint procedures are initiated when a patient's self-control fails, leading to injury or threat of injury to self or others. When restraint is done to a child patient it is an extension of the already existing formal system of external controls that society provides in recognition of the dangers implicit in children's intrinsic limitations in judgment and self-control.⁴ However,

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seclusion and restraint should be used only when they are deemed the only measures adequate and available to meet the needs of the situation. ~
Justification for Seclusion and Restraint

One of the strongest justifications for restraint is for the protection of the person, of others, or of both. Lack of alternatives and beneficial therapeutic effects of restraint and seclusion are some strong justifications for their use. Several authors have stated that there are psychiatric emergency situations where medication and verbal therapies are insufficient to control volatile situations. 6

It's been stated that the clinical reality is that few patients are ever totally out of control. Also, few patients ever want to be in the state of loss of control. External control, however much it is fought against, is also welcome.⁷ This can be shown when patients ask worriedly if they can be managed when they are aware that there is a shortage of staff on a certain shift. It has also been reported that when structural damage to seclusion room doors at a children's mental hospital made it easy for children to break out of seclusion the incidence of episodes calling for restraint escalated dramatically. When the doors were repaired, the incidence fell precipitously.⁸ Non-support for Seclusion and Restraint

In the area of restraint and seclusion, there are many who fear its abuse and psychological, physical and emotional consequences. Seclusion and

⁵Gair, Guidelines for children and adolescents, in Tardiff K (ed): The Psychiatric Uses of Seclusion and Washington DC, American Psychiatric Press, 1984, p. 84. ⁶Telintelo, S., Kuhlman, T.L., & Winget, C. (1983). A study of the use of restraint in a psychiatric emergency room. Hospital and Community Psychiatry 34, 164-165.

⁷Gair, ~u~ra note 1, at 356.

⁸Gair, ~ note 5, at 69-85.

restraint may involve physical and psychological risks.⁹ It may also produce negative reactions in patients and staff. Others report that seclusion or restraint may be used as punishment to patients.¹¹ Another concern is that seclusion or restraint may be used more frequently due to staffing shortages.¹² Lastly, seclusion or restraint may be an infringement of civil rights.¹³

Some believe that we cannot restrain someone and help him at the same time. Senator Backman, in his press release vowed to abolish all restraint of children, stated: I do not believe that a psychiatrist or psychologist or social worker or priest or rabbi can say to a child, 'I want to help you,' and then lock the child up.

Also it has been argued that many decisions to restrain are not medical decisions at all. For example, what degree or imminence of danger justifies restraints? And do the social consequences of mental regression justify restraints? These questions may deal with social and moral values such as the importance of freedom and the rights of the individual against the group.

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These concerns address the uncertainty in the consequences and use of restraint and seclusion. However, these issues have been addressed to a certain degree, and due to the fact that the use of restraint and seclusion for children continues to be used throughout the country, perhaps the benefits outweigh the costs.

⁹Nelson, S.H., McKinney, A., Ludwig, K., & Davis, R. (1983). An unusual death of a patient in seclusion. Hospital and Community Psychiatry 34, 259.

¹⁰Binder, R.L., & McCoy, S.M. (1983). A study of patients' attitudes toward placement in seclusion. Hospital and Community Psychiatry 34, 1052-1054.

¹¹Binder, R.L. (1979). The use of seclusion on an inpatient crisis intervention unit. Hospital and Community Psychiatry 30, 266-269.

¹²Hay, D., & Cromwell, R. (1980). Reducing the use of full-leather restraints on an acute adult inpatient ward. Hospital and Community Psychiatry 31, 198-200.

¹³Oldham, J., Russakoff, L.M., & Prusnoffsky L. (1983). Seclusion: Patterns and Millieu. Journal of Nervous and Mental Disease 171, 645-650; Youngberg v. Romeo (1982), 102 S.Ct. 2452. ¹⁴Saks, Elyn R. (1986). Mechanical Restraints. Yale Law Journal 95, 1850.

For example, it was suggested that seclusion and restraint may be used for staff convenience regardless of patient need and that with less staff and more patients, seclusion and restraint would be used more frequently. However, a study of New York State Psychiatric Centers found little evidence of this. Most of the orders were written during the day shift and on weekdays when staff was most plentiful. There was a lack of relationship between patient/staff ratio and precipitating cause (violent/non-violent), receiving PRN medications, and spending less time than was ordered. This study undermined the hypothesis that seclusion and restraint is used for staff convenience regardless of patient need.¹⁵

History of Seclusion and Restraint

Throughout history, the practice of restraint and seclusion have been associated with punishment, custodial care, institutional abuse and neglect. Restraint is not a scientific discovery. Its origins go back to primitive societies as a natural response to the danger presented to the public by a deranged member of society.¹⁶ These individuals were banished, tied down, or caged. The decreases in these practices have been associated with reform, moral progress, and humanitarianism.¹⁷ It may have started with Pinel's partial removal of chains from patients in a Parisian Hospital in the 1790s.¹⁸ And it may have progressed to the 1950s Boston hospital study of negative factors sustaining the practice of seclusion.¹⁹

¹⁵Way, Bruce B. (1986). The Use of Restraint and Seclusion in New York State Psychiatric Centers, International Journal of Law and Psychiatry 8, 383-393.

¹⁶Westermeyer, J., Kroll, J. (1978). Violence and mental illness in a peasant society:

Characteristics of violent behaviors and folk use of restraints. British Journal of Psychiatry 133, 529-541.

¹⁷Gair, supra note 1, at 443.

¹⁸Pinel, A. (1962). A treatise on insanity (D.D. Davis, Trans.). New York: New York Academy of Medicine, Hafner Publishing. (Reprinted in facsimile from original work published in 1806).

¹⁹Greenblatt, M., York, R.H., & Brown, E.L. (1955). From custodial to therapeutic patient care. New York: Russell Sage Foundation.

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It is easy to see the natural abhorrence to this type of treatment. However, today, the restraint and seclusion of individuals is still being used. Although it may be quite offensive to individuals in our society, the professionals for the most part have recognized the need for restraint. Therapeutic Value of Seclusion

There is evidence of the therapeutic value of seclusion procedures when properly applied. Without an understanding of the purpose and therapeutic value for seclusion and restraint, it is more likely to be implemented poorly, to the detriment of the patients and the morale of the staff who care for them. 20 It has been recognized by physicians that the regular imposition of predictable restraints following episodes of undesirable loss of control has an observable effect on the patient's increasing self-control.²¹ Often patients will ask for periods in a seclusion room rather than having to go out of control. In some places such as Washington D.C., Georgia and in Massachusetts by judicial review on a case-by-case basis, seclusion and restraint may be used as part of a specific treatment program. However, the law generally prohibits the use of restraint as a treatment procedure.

It has been found that seclusion can be used effectively for some children as an essential step in the process of learning control through the experience of control. The experience can introduce positive coping skills as leaving the scene for awhile, seeking solace in quiet places, using privacy to think about a situation, waiting before reacting when frustrated, taking the consequences of a minor infraction without creating a major problem.²²

20 Cotton, Nancy S. (1989). The Developmental-Clinical Rationale for the use of Seclusion in the Psychiatric Treatment of Children. American Journal of Orthopsychiatry 59(3), 442. ²¹Gair, D.S., Bullard, D.M., Corwin J.H., (1965): Residential treatment Seclusion of children as a therapeutic ward practice. American Journal of Orthopsychiatry 35, 251-252. ²²Gair, supra note 1, at 448.

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Restraint and seclusion is used frequently by adults to teach their children and not to retaliate. For example, a child being sent to her room is a frequent form of discipline used in the homes of many parents. The argument can be made that the use of seclusion in a hospital ward is used in the same way and can be used effectively as part of the discipline process whenever the child is unable to do work on the process herself. In addition, the restraint should be explained to the child that it is only for protection and not punishment and that the restraints will be removed once it is safe.

In order for seclusion to be therapeutic it must provide physical, but never psychological, separation from people and situations.²³ If the staff are angry, the handling is rough, or the room physically unattractive, seclusion can represent another abandonment for the child. Conversely, if the staff are firm yet caring, if the room is comfortable and safe, then the child may be better able to experience the separation as a protective, reasonable, and caring response to impulsive behavior or inability to cope with the environment. ²⁴ A good example of this is the seclusion room at New England Memorial Hospital which was built to resemble a child's den with a low bench, carpeting, a pleasant outdoor view through an unbreakable plexiglass, and a window into the director's office. ²⁵ This kind of environment was designed to make the negative potential of seclusion as minimal as possible by keeping the child in contact with people and making the room as comfortable as possible. Unfortunately, not every hospital has the amenities and therapeutic milieu as the New England Memorial Hospital.

at 448-449.

at 449.

²⁵Cotton, N. & Geraty, R.G. (1984). Therapeutic space design: Planning an inpatient children's unit. American Journal of Orthopsychiatry 54, 624-636.

However, there are many factors involved in making the seclusion process as therapeutic as possible. The policies must be defined, conducted in a consistent manner; explained to the child; administered by well-trained professional and humanitarian staff; supervised by a trained staff; and the space must be safe, attractive, and soothing. 26

Three empirical studies conducted on the use of seclusion or quiet-room (door unlocked) use on school-age units all demonstrate that seclusion and quiet rooms are integral to the treatment practices of the inpatient psychiatry units.²⁷ Data from these papers suggest that the use of seclusion for children is different than that of adults, being more frequent and for briefer periods in the case of children. The study also found that children who are likely candidates for seclusion have certain characteristics. Biologically, they often have pathological family histories, attentional and learning problems, and neurological impairments. Psychologically, they have poor self-esteem, defective object-relations, poor impulse control, maladaptive coping strategies, and immature defenses. Socially, they often live in poverty with family histories of loss, violence, neglect, and abuse. Obviously, if the child and family is going through a maladaptive cycle intervention is necessary. 28

Comparing chemical, mechanical, physical restraint and seclusion

There is controversy as to the hierarchy of the relative restrictiveness between chemical and physical restraint and seclusion. A survey of Arizona

²⁶Cotton, *supra* note 20, at 449.

²⁷Garrison, W.T. (1984). Aggressive behavior, seclusion and physical restraint in an inpatient child population. Journal of the American Academy of Child Psychiatry 23, 448-452; Joshhi, P.T., Capozzoli, J.A., & Coyle, J.T. (1988). Use of the quiet

room on a children's inpatient unit. American Academy of Child and Adolescent Psychiatry 27, 642-644; Millstein, K.H. (1986). A study of factors predictive of the need for seclusion in latency-age h

ps~cbii~rbl~zm. Unpublished doctoral dissertation, Boston College.
LSCotton, *supra* note 20, at 444.

²⁹ Gair, *supra* note 1, at 389.

³⁰ *Id.* at 75.

³¹ Way, *supra*..note 15

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state mental health program directors shows that seclusion is to be used after all else except restraints fail, and this includes chemical restraint. This differs from the New Hampshire guidelines which seem to indicate that, seclusion is the least restrictive, followed by physical restraints, and then chemical ones.

There is much debate as to what types of restraint are superior to others. In fact, authorities on the subject vary greatly on their ranking of restraints and seclusion. There may be differences between seclusion and restraint in cost, probability of serious staff injury, requirements of staff time to monitor and implement, and the impact on staff and patient attitudes. ²⁹ The merits of one procedure may vary depending on variables such as patient and staff composition, type of ward, and ward atmosphere.

It has been argued that it is unwise to have a hospital use a variety of different procedures to handle seclusion and restraint because it would be confusing for the staff.³⁰ A 1984 study was done on the use of seclusion and restraint of all New York state-operated psychiatric hospitals. It was found that most hospitals in the study used almost exclusively only one technique—seclusion or restraint—to deal with similar psychiatric emergencies.³¹

Some argue that the type of restraint or seclusion used should be determined by what is in the best interest of the child. Characteristics of the child (e.g., psychiatric diagnosis, strengths, family history) should determine what should occur at any point in treatment. And that seclusion or restraint should be used on the basis of the developmental and clinical status of the child, not on the general protocols or staff preferences. For example, it may be better to physically hold rather than seclude a young child who is still gaining controls within attachments to emotionally important adults. Adolescents

may benefit more from mechanical restraints within which they can regain control independently of adults from whom, they may need to separate. Also, psychopharmacological interventions may be more problematic for children in families with a history of drug or alcohol abuse because this may be associated with trauma in a child's experience.³²

Some argue a patient should have a choice among appropriate control measures, even if the patients are of questionable competence, because of the lack of consensus in the medical community of any particular ranking of these measures. For example, it has been shown that adult patients overwhelmingly prefer seclusion to restraints.³³ A patient in a seclusion room can move around if he wants to whereas a patient in restraints can do nothing. Also a patient in restraints suffers the physical pain of forced immobility. Restraints can also violate one's dignity more than seclusion. Nothing in someone's day-to-day routine prepares one for being strapped down, while being alone in a room—even a locked room—is a part of most individuals' life experiences.³⁴ If restraints fulfill the same purpose as seclusion, and seclusion is preferred by patients, perhaps restraints should be confined to when there is an imminent danger of harm to self. Seclusion may also be substituted when there is danger of harm to others, but not to self.

Restraint requires direct close physical contact between staff and child therefore the relationship between staff and children is of great importance. The effects of such procedures on mental health professionals must also be considered. There can be much emotional tension when dealing with restraint. There is the eye for an eye phenomenon, where many times the

³²Cotton, *supra* note 20, at 447.

³³Soliday, (1985). A Comparison of Patient and Staff Attitudes toward Seclusion, 173 *J. of Nervous & Mental Disease*. 173, 284 (74% of patients surveyed think restraints are more unpleasant than seclusion).

³⁴Saks, *supra* note 14, 1852.

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staff will want to retaliate if hit, scratched, bit, kicked or spit at. This retaliatory tendency must be neutralized in order for workers to provide humane care. Also, understandably, interactions can have a long-lasting effect on the children and family members.³⁵ Obviously, further research needs to be done in this area.

Physical Restraint

The use of holding may provide body contact between a young patient and one or more staff members. This type of restraint may seem more humane than the other types of restraint, however, there are limits to this type of restraint. For example, when a patient is in a violent state, physical restraining by others may be inflammatory. 36 Conversely, when a patient is placed in a seclusion room, it is shown that a calming process begins. This is attributed to the huge reduction in stimulation that comes from being secluded.³⁷ In addition, physical holding for every patient would require an exorbitant and impractical number of staff. Children even seven to eight years old may require as many as five adults for safe physical management. Chemical Restraint

Chemical restraint is given by a physician order who must be adequately knowledgeable about the circumstances. However, in many jurisdictions, in the case of an emergency, chemical restraint may be used in the absence of specific permission, but if there is any doubt, a staff member may get authorization from a judge. In states such as Massachusetts there are judges on 24-hour call for such emergency decisions.

³⁵Gair, supra note 1, at 361.

³⁶J.

³⁷Gutheil T. (1978). Observations on the theoretical bases for seclusion of the psychiatric inpatient. American Journal of Psychiatry 135, 325-328.

38 Gair, *supra*, note 1, at 361.
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There is always a risk from any major tranquilizer. However, self-mutilating behavior and persistent violent physical struggling against mechanical restraints with the risk of exhaustion may require the need for chemical restraint. 38

Youngberg v. Romeo

In a 1982 U.S. Supreme Court case, Youngberg v. Romeo 102 Supreme Ct. 2452 (1982), the Court viewed restraint and seclusion as best regulated by internal professional norms and therefore deferred to professional judgment and clinical considerations. Youngberg v. Romeo involved the rights of an involuntary institutionalized developmentally disabled person to be free from bodily restraint. The Supreme Court held that committed patients are constitutionally entitled to personal security and to freedom from bodily restraint, however, the court qualified those rights substantially. The court also held that a patient is entitled to training in order to avoid unconstitutional infringement of his rights to bodily safety and freedom from physical restraints. The Court in B m ~ recognized that there are occasions in which it is necessary for the State to restrain the movement of residents

to protect them as well as others from violence. Similar restraints may also be appropriate in a training program. And an institution cannot protect its residents from all danger of violence if it is to permit them to have any freedom of movement. (at 2460).

Although the Supreme Court found patients to possess an interest in safety, an interest in freedom from bodily restraint, and to a lesser extent, an interest in habilitation, the Court found these interests to not be absolute and that the interests in bodily safety and bodily freedom are to some degree in

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conflict (at 2460). The constitutional standard used by the Court requires that the courts make certain professional judgment in fact was exercised. (at 2461). However, if a lawsuit alleging constitutional deprivation is filed following the seclusion or restraint of a patient, the decision, if made by a professional, is presumptively valid and liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice or standard as to demonstrate that the person responsible actually did not base the decision on such a judgment. (at 2462).

The court also defined professional broadly, encompassing a person competent, whether by education, training, or experience to make the particular decision at issue (at 2462). The Court acknowledged that *day-to-day* decisions regarding care — including decisions that must be made without delay — necessarily will be made in many instances by employees without formal training but who are subject to the supervision of qualified persons (at 2462). The Court also noted that individual professionals would not be liable if professional standards were unable to be satisfied because of budgetary constraints. RQm~ seems greatly concerned with institutional administration.

The Court stated that it is not appropriate for the courts to specify which of several professionally acceptable choices should have been made (at 2461). Before EQm~, several courts found constitutional reasons to require specific procedures attending seclusion or restraint, among them: that patients be personally examined by a qualified mental health professional prior to restraint and by a psychiatrist within two hours of restraint; that patients be checked every 15 minutes and that reevaluation occur within 12

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hours.³⁹ After the *I v. M* decision these procedures seem too specific to be constitutionally required, however Paul Appelbaum has stated that many of them are merely elaborations of good clinical practices that should be followed everywhere.

Therefore, state statutes, administrative regulations, and institutional policies may establish strict standards regarding the use of seclusion and restraint although the promulgation of such standards is not constitutionally required. Some physicians desire standards not only because this would probably help codify good clinical practice, but if followed, would probably protect professionals from legal liability.⁴⁰

The Supreme Court in *Youngberg v. Romeo* granted the professional much leeway in making a decision on restraining or secluding a patient. Perhaps the Court realized that if it didn't allow presumptively valid professional judgment, every clinical decision would be subject to adversarial debate and would paralyze hospital management. There is a constant tension among physicians and the legal system. Many physicians feel that restrictions are placed on them by those who are not in the best position to know and this hinders their performance as physicians and can actually do more harm than good. For example, in 1984 a bill banning seclusion (but not mechanical restraints) for all children under eighteen in licensed psychiatric hospitals went into effect in Massachusetts.⁴¹ This caused great difficulties in facilities with children who frequently needed to be secluded. Many of these children had to be held or mechanically restrained instead of being placed in a seclusion room and they protested the change. 42 After professional groups

³⁹*Id.* at 289.

⁴⁰Wexler, David B. (1982). Seclusion and Restraint: Lessons from Law, Psychiatry, and Psychology. *International Journal of Law and Psychiatry* 5,287.

⁴¹Massachusetts General Laws, Chapter 464, Acts 1984.

⁴²Gair supra note 1.

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lobbied intensely for rescinding the change, new legislation permitted seclusion for children under eighteen years after assuring that proper procedures and monitoring are in place.

However, sometimes state legislation yields a positive result as shown by an attempt in 1985 to reduce the rates of restraint in children in Massachusetts. In 1985, Massachusetts implemented a restrictive state law to regulate the psychiatric use of restraint. Indeed, the result was as hypothesized as the total number of hours in restraint was reduced significantly on a child and adolescent unit. The number of patients and episodes of chemical restraint on the unit were not significantly affected. The use of chemical restraints were not affected by the law because staff had already used chemical restraints sparingly. Also, the Massachusetts case Rogers et al v. Commissioner of the Department of Mental Health et al. 390 Mass. 489 (1983), which attempted to regulate the forced use of medication influenced the staff. The study concluded that there are a variety of factors which may influence the reduction of restraint in different facilities. Factors such as the number of children with problems in impulse control, crowding, staffing patterns, and the philosophy of the staff.

Liability for abuse of seclusion and restraint

The superintendent or director of any hospital has ultimate civil and professional responsibility for the safety, well-being, and relevant rights of all patients under his or her care. Therefore, all the events that occur in a psychiatric hospital for children are the legal responsibility of the superintendent or director. Although all staff members have legal responsibility for their own actions, it is only partial compared to that of the director. However, it has been recognized that the great majority of the time

seclusion or restraint is implemented when a physician is not immediately present. In most psychiatric wards, the nursing staff are the only ones constantly present with the children. Therefore they need to be able to recognize the need for seclusion. However, after seclusion has occurred, the physician should take an active role in monitoring the child. Therefore, a psychiatrist in charge of a ward should regularly review and discuss with the staff situations and judgments leading to seclusion, techniques used, assessment of children's readiness to leave seclusion, and the apparent overall effects.

There should be liability for unreasonably restraining patients. It should not be set so high as to risk jury nullification, nor so low as to become merely a cost of doing business. Also, doctors should not be held liable for injuries resulting from a failure to restrain patients, unless a person of the most common understanding would have foreseen serious injuries of the kind described in the statute. This would at least recognize the doctor's limits in predicting violence.

When Should a Child be Secluded or Restrained?

There have been attempts to establish guidelines to reduce the negative aspects of seclusion/restraint by determining when seclusion/restraint should be used.⁴⁶ One of the guidelines has been offered by the American Psychiatric Association. Two authorities on seclusion and restraint, Gutheil and Tardiff, developed the following five clinical indications for

⁴³Gair, *supra* note 1, at 78.

⁴⁴Saks, *supra* note 14, at 1855. ⁴⁵*Id.*

⁴⁶McCoy, S. M., & Garritson 5. (1983). Seclusion: The process of intervening. *Journal of Psychosocial Nursing and Mental Health Services* 21, 9-15.

⁴⁷American Psychiatric Association (1984). Seclusion and Restraint: The Psychiatric Uses. Report of the American Psychiatric Association Task Force on the Psychiatric Uses of Restraint and Seclusion, Washington: American Psychiatric Association.

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restraints of all patients in the American Psychiatric Association Task Force on Seclusion and Restraint. These indications arise with hospitalized children: (a) to prevent imminent harm to the patient or other persons when other means of control are not effective or appropriate; (b) to prevent serious disruption of the treatment program or significant damage to the physical environment; (c) to assist in treatment as part of ongoing behavior therapy; (d) to decrease the stimulation a patient receives (pertaining solely to seclusion); and (e) to comply with a patient's request.⁴⁸ Although these are very well authorized indications for the restraint or seclusion of a patient, in some states, such as Massachusetts, the only basis for restraint is basically the presence of violent behavior to self or others or its imminent threat.⁴⁹ The prevention of disruption of program or damage to environment is not a permissible reason for restraint in many states. However, if this leads to violent behavior the child would need to be restrained.

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Justification for restraint based on the prevention of imminent harm depends on the likelihood of further violence. 51 An obvious example is when a patient is engaged in actual violent conduct or makes a serious threat or attempt to engage in violent behavior. A more difficult case is when there is no specific violent act, threat, or attempt on the part of the patient, but rather, for example, a significant change in behavior. Most likely, a clinician will be supported by the EQm~.Q case if action is taken, if clinical judgment is used and especially if it is known that a particular behavior is a precursor to violence or to other serious uncontrollable behavior.⁵² Soloff, Gutheil, and

Gutheil TG, Tardiff K: Indications and contraindications for seclusion and restraint, in Tardiff K (ed): The Psychiatric Uses of Seclusion and Restraint. Washington DC, American Psychiatric Press, 1984, pp 11-17.

~9Gair, supra note 1, at 356.

⁵⁰Id at 357.

at 356.

⁵² at 288.

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Wexler (1985) state: there is overwhelming empirical support for using seclusion and restraint to limit the progressive disorganization of behavior prior to actual violence (p. 657).⁵³ It has been stated that it is the obligation of the staff to intercede early,..., and that it is not therapeutic for a patient to be required to assault another person in order to obtain the containment he may need. 54

The Different Types of Restraint statutes.

Restraint statutes may be divided into seven categories. One type of statute requires that the use of restraints be recorded. Second are statutes that proscribe unnecessary or excessive restraints. Third are statutes that require restraints to be prescribed by a designated authority, usually a physician. Fourth are statutes that allow restraints only if required by the medical needs of the patient. Fifth are statutes that allow restraints for either safety in an emergency or on a professional's written order explaining the rationale for the restraint. Sixth are statutes that allow restraints for either the safety or the treatment of the patient. And seventh are the statutes that require dangerousness to self or others. ~ Lacking in most state statutes are the amount of restraint exercised which is required to achieve the desired result and the allowance of patient choice.⁵⁶

⁵³Soloff, Ph.H., Gutheil, T.G., & Wexler, D.B. (1985). Seclusion and restraint in 1985: A review and update. Hospital and Community Psychiatry 36, 652-657.

⁵⁴Oldham, J., Russakoff, L.M., & Prusnofsky L. (1983). Seclusion: Patterns and milieu. Journal of Nervous and Mental Disease 171, 645-650.

⁵⁵Saks, supra note 14, at 1841.

⁵⁶jj 1842.

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Conclusion

It is the hope that the use of seclusion and restraint would be rendered obsolete by such advances in the field of psychiatry such as the use of psychopharmacology and the therapeutic milieu.⁵⁷ However, this goal has not been realized as studies combining data on seclusion and restraint reveal an incidence of use varying from 2% to 66%. In order to reach the goal of rendering obsolete the use of seclusion and restraint, more research needs to be done in understanding mental illness. Currently, medications can alleviate some of the symptoms of mental illness, but they cannot cure the illness. And to safely and effectively utilize seclusion and restraint, more research should be done on seclusion and restraint practices across a wide range of psychiatric treatment settings.

Guidelines should be developed in every psychiatric setting dealing with when to act, whether to administer seclusion or restraint, and the duration of seclusion and restraint. Guidelines are necessary because not only can it give the clinician some general guidance, but abuses can occur when someone is given unfettered discretion. In addition, physicians may not take the time and effort to keep up-to-date on new techniques and information.

Those of us who are uninvolved in the day-to-day life in a mental institution are unlikely to understand the dynamics of a mental institution as well as as the reality of the need for restraints. Clinicians many times are in a catch-22 situation. On the one hand a patient has a right to be free from

⁵⁷Soloff, P.H. (1984). Historical notes on seclusion and restraint. In K. Tardiff (Ed.), *Psychiatric Uses of Seclusion and Restraint* (pp. 1-9). Washington, D.C.: American Psychiatric Press.

⁵⁸Soloff P.H., Gutheil, T.G., & Wexler, D.B. (1985). Seclusion and restraint in 19485: A review and update. Hospital and Community Psychiatry 36,652-657.

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unnecessary seclusion and restraint. On the other hand, patients in the ward have a right to be protected against assaultive behavior.

It is the goal of medicine to give care and treatment without the infliction of pain, but pain unfortunately accompanies some treatments. Hippocrates stated *primum, non nocere*, (first, do no harm), but pain is not synonymous with harm. Some may argue that seclusion and restraint is like that of a cast to a broken bone. A cast is not what one would consider an aversive treatment of a fracture, yet it is a type of restraint and it aids in growth. Seclusion and restraint is not welcomed by a child even though there may be evidence that he is reassured by it. And this may feel like punishment for the child. But properly brought up children will feel victimized as necessary limits are placed on them. However, the limits and restrictions must not be excessive. Basically, all children need basic care and protection. And as Donald Gair stated, Mentally ill and disabled children surely need even more.